Homelessness in Female-Headed Families: Childhood and Adult Risk and Protective Factors

ABSTRACT

Objectives. To identify risk and protective factors for family homelessness, a case–control study of homeless and low-income, never-homeless families, all female-headed, was conducted.

Methods. Homeless mothers (n = 220) were enrolled from family shelters in Worcester, Mass. Low-income housed mothers receiving welfare (n = 216) formed the comparison group. The women completed an interview covering socioeconomic, social support, victimization, mental health, substance use, and health domains.

Results. Childhood predictors of family homelessness included foster care placement and respondent's mother's use of drugs. Independent risk factors in adulthood included minority status, recent move to Worcester, recent eviction, interpersonal conflict, frequent alcohol or heroin use, and recent hospitalization for a mental health problem. Protective factors included being a primary tenant, receiving cash assistance or a housing subsidy, graduating from high school, and having a larger social network.

Conclusions. Factors that compromise an individual's economic and social resources are associated with greater risk of losing one's home. (*Am J Public Health.* 1997;87: 241–248)

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Introduction

Homelessness remains a persistent and tragic social problem experienced all too frequently by single adults, families, and unaccompanied youth. In the mid-1980s, women and their children changed the face of homelessness in the United States.[1] However, despite the growing numbers of homeless families, only a few studies have described factors that increase the risk of or protect families against homelessness.[2–7]

Discussions about the causes of homelessness have pitted structural and systemic variables against individual-level characteristics, sharply polarizing the issues. The question of why homelessness exists as a major social problem has been confused with the question of who is most likely to become homeless.[8–12] Macro-level factors, such as housing supply and demand, the gap between median rents and income, number of housing subsidies, and increasing poverty levels help explain why family homelessness exists, but they do not identify which families are most vulnerable to becoming homeless.

Previous studies on family homelessness have had limited assessments of risk and protective factors and have not conducted multivariate analyses. Findings across these studies have been inconsistent, particularly with regard to violent victimization and social supports.[2–6] These differences may be due to varying definitions and sampling strategies, choice of comparison groups, timing of interviews in relation to the homelessness episode, comprehensiveness of interviews, specificity in the temporal ordering of variables, or differences in location and time periods in which the studies were conducted.[2–7] However, most researchers have reported higher prevalence rates of victimization, mental disorders, substance abuse, and insufficient economic resources among homeless than among housed mothers.[2,3,7]

This case–control study aimed to identify individual-level risk factors that increase the likelihood of a female-headed family's becoming homeless and was designed to address the methodological limitations of earlier research. Guided by previous findings, we assessed each participant across economic, social, psychological, and health domains, using standardized instruments to measure a wide range of risk and protective factors. In particular, we were interested in identifying distal risk factors that arise during developmental years, such as foster care or physical or sexual abuse, as well as factors that occur in early adulthood. Additionally, we asked women about factors in their current lives that may be proximal antecedents or precipitants of

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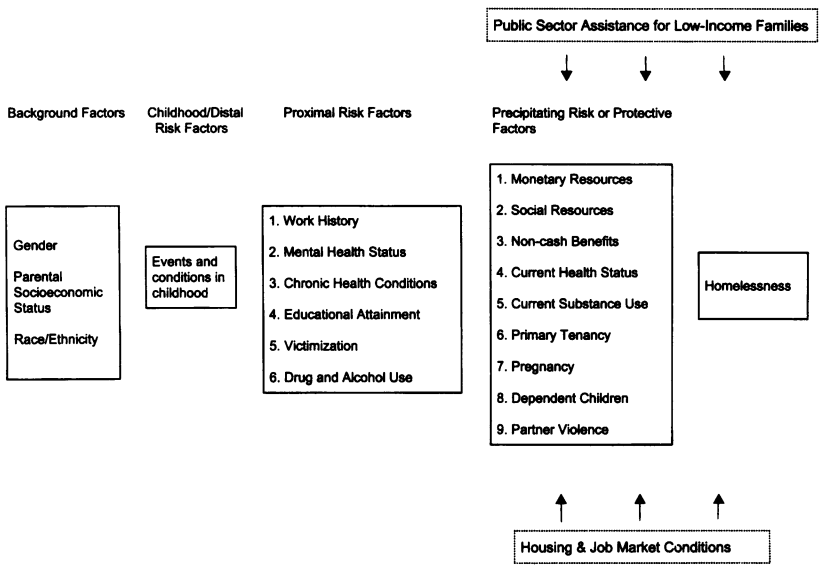

Source. Adapted, with permission, from Susser et al.[14]

FIGURE 1—Risk and protective factors for family homelessness.

homelessness, including income, work and housing histories, life events, social supports, and mental and physical health. Descriptive findings across these major domains have been reported previously.[13] The focus of this paper is to identify, through multivariate modeling, those variables that meaningfully distinguish homeless from housed mothers in an effort to better understand vulnerability to family homelessness.

The conceptual framework used in developing the interview and in model building is consistent with that of Susser and colleagues, who differentiate among background (e.g., sociodemographic), childhood, adult, and precipitating factors in understanding pathways into homelessness (see Figure 1).[14] On the basis of prior research, we hypothesized that homelessness among female-headed families would be predicted by factors that compromise the mother's social and economic resources (e.g., violent victimization, mental health or substance abuse problems) or reflect a diminution of such resources (e.g., small social network, annual income). Given recent welfare reform and the block granting of antipoverty programs to the states, empirical findings are critical for developing policies and programs targeted to preventing family homelessness.

Methods

Participants and Enrollment Procedures

An unmatched case–control design was used to recruit a sample of sheltered homeless families and a comparison group of low-income housed (never homeless) families in Worcester, Mass. Worcester is Massachusetts' second largest city, with a population of 169 000; 15% of its residents live below the poverty line.

As in many mid- and large-size American cities, the vast majority of homeless families in Massachusetts are headed by women. In Worcester, almost all families who become homeless go directly to a shelter as opposed to sleeping in a park, car, or abandoned building. Thus, we enrolled only mothers currently living in shelter with their dependent children under the age of 17.

Between August 1992 and July 1995, 220 homeless families were enrolled from all nine of Worcester's emergency shelters and transitional housing facilities, as well as from two welfare hotels (3.2% of the families). Study staff approached families who had been in shelter for at least 7 days and asked the mothers to participate in multisession interviews. The majority (75%) of the 220 women interviewed were new entrants into the shelter system, having spent less than 18 weeks in shelter at the time of enrollment (median = 8 weeks). For the majority of families (76.4%), this was their first homeless experience; 52 families (23.6%) had been homeless on at least one occasion prior to their enrollment in this study. While we attempted to enroll all families living in shelter, we did not interview an estimated 20 to 30 women who stayed in shelter for a short time and an additional 102 who refused. Women who refused were similar to those who completed the interview in terms of race, marital status, and number of children. Those who refused were younger (24.2 years vs 26.1 years) and less likely to have graduated from high school (25% vs 34%).

The comparison group of 216 families was enrolled from among never-homeless female-headed families who were receiving Aid to Families with Dependent Children (AFDC) and residing in public or private housing. Following epidemiologic principles,[15–17] this comparison group was chosen to represent the base population from which cases emerge. Our intent was to select a comparison group of families who had never been homeless but were at economic risk for the condition. Following the US Congress's definition, for the comparison group, never being homeless meant never "having spent more than seven consecutive nights in a car, abandoned building, public park (except voluntary camping), shelter, non-residential building, or other non-dwelling."[18] We did not match cases and controls, as the literature does not suggest risk factors for family homelessness (beyond poverty) that should be controlled through study design.

Project staff enrolled the comparison group by approaching women at the Worcester Department of Public Welfare office. (We were not able to gain permission from the Department to construct a sampling frame). The women we recruited were primarily coming to the Department of Public Welfare for redetermination of their benefits eligibility, which requires a face-to-face appointment. These appointments are scheduled routinely, usually at 6-month intervals. We were thus able to capitalize on an efficient process for randomly recruiting women on AFDC into our study. One hundred forty-eight women refused to participate as members of the housed comparison group but we were able to collect basic information about them. These refusers were similar to the housed

women who completed the interview in terms of age, marital status, and number of children. However, they were slightly more likely to be Puerto Rican (49% vs 36%) and less likely to be White (38% vs 45%), as well as less likely to have graduated from high school (40% vs 50%), compared with those who completed the interview.

We were able to collect somewhat more detailed information on women who dropped out of the study before completing all interview sessions. The 39 homeless women who dropped out were less likely to have been in foster care than the 220 homeless women who completed all interviews. Also, the 31 housed women who dropped out were less likely than the 216 who completed all sessions to have graduated from high school; they had also lived in Worcester 4 years less, on average. However, on all other demographic, income, and housing variables, the women who dropped out were similar to the women who completed all interviews.

Representativeness of the Sample

With respect to age and number of children, our homeless sample is comparable to sheltered homeless families in nine large American cities.[19] However, our sample has a greater percentage of Hispanics and fewer Blacks. The comparison group resembles Worcester's AFDC population in terms of race/ethnicity and age.[20] Compared with women receiving AFDC,[21,22] the comparison group is similar in terms of age, education, and number of children, but the proportion of Hispanics is greater (42% vs 18%) and the proportion of Blacks much lower (10% vs 45%).

Data Collection and Instruments

Highly trained female interviewers collected data on mothers in interviews carried out over three or four sessions of approximately 2 hours each. Homeless women were typically interviewed in a private room at the shelter and housed women were interviewed in their homes or at a community-based project office. As compensation for each interview session, respondents received $10 vouchers redeemable for merchandise at local stores.

Existing instruments and original questions were used to develop an interview protocol to obtain information on demographic characteristics, factors in the mothers' childhood and adulthood that might influence the risk for and consequences of homelessness, and service use. We selected instruments and modified questions to be sensitive to cultural issues. Because of the high percentage of Hispanic participants, the entire protocol was translated into Spanish by bilingual and bicultural translators. Overall, instruments had to have proven reliability and validity, as well as previous use with or appropriateness for homeless, low-income, and minority populations. Time frames were specified to help distinguish antecedents from consequences of homelessness. For instance, some questions on risk factors were asked of the comparison group relative to the past 6 months or year, whereas the same questions were asked of homeless women about a comparable time period prior to their becoming homeless.

A modified version of the Personal History Form—an instrument designed for use with homeless and low-income persons—was used to assess housing, income, education, jobs, and family structure.[23] We asked respondents questions, based on the Life Experiences Survey,[24] about life events experienced within the past 2 years. A count of 11 severe life events (e.g., death of spouse/partner, parent, child; hospitalization of self, child; car accident) was created. The Personal Assessment of Social Supports[25] (PASS) was used to assess mothers' social network and resource base. This instrument was developed and validated on low-income families with preschool children. Mothers were asked to name up to 10 persons who played a positive or negative role in their lives and then were asked about the quality of the first seven relationships. Qualitative dimensions included emotional support, willingness to provide resources, and conflict. In addition, to assess whether network members had basic resources such as money, food, and shelter, items from the Family Resource Scale were incorporated into the PASS.[26] We counted the size of a woman's social network (range, 0–7) as well as nine separate material resources potentially available from network members (range, 0–63).

The Conflict Tactics Scales[27] were used to assess severe physical violence by childhood caretakers and by intimate as well as nonintimate males in adulthood. Childhood sexual molestation was defined as "any kind of sexual advance or unwanted sexual experience from touching to more serious behaviors" by any adult or other individual older than the respondent that occurred before the respondent turned 18.

To assess the lifetime and current (within the last 30 days) prevalence of Axis I *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), third edition, revised, mental and substance use disorders, we used the Structured Clinical Interview for DSM-III-R—Non-Patient Version.[28] We also asked questions specific to alcohol, cocaine, and other drugs. Frequent alcohol use was defined as three or more drinks daily or nearly every day over the past 2 years for the comparison group and 2 years prior to becoming homeless for the homeless group. Frequent use of marijuana, cocaine, heroin, or sedatives was defined as use three times per month or more over the same 2-year period. Finally, respondents were asked about chronic health conditions. For additional detail on methods see Bassuk et al.[13]

Data Analysis

Programmatic and policy considerations suggest the importance of developing explanatory models of vulnerability to homelessness for female-headed families that consider childhood and adulthood factors separately and in combination. Variables examined as risk or protective factors were those that researchers had previously associated with family homelessness, or that we hypothesized as increasing vulnerability to homelessness because of their potential adverse impact on economic and social resources. Potential explanatory variables covered the domains of housing; work, income, and benefits; life events; social networks; physical and sexual violence; mental and physical health; alcohol and other drug use; problems with the legal system; characteristics of intimate male partners in adulthood; and factors related to motherhood. Most of these variables are listed in Table 1 (space constraints limit the inclusion of all variables examined). In univariate analyses, the relationship between each hypothesized predictor and housing status was first assessed by means of two-tailed *t* tests or Wilcoxon rank-sum tests for continuous variables and chi-square tests for discrete variables. Two multivariate models were then developed: (1) a model that considered only childhood risk factors for homelessness and (2) a model of proximal and precipitating factors in adulthood that controlled for significant childhood predictors emerging from the first model.

For both the childhood and adult multivariate models, we employed a stepwise selection algorithm, using SAS

TABLE 1—Potential Risk and Protective Factors for Homelessness: Homeless and Poor Housed Mothers in Worcester, Mass, 1992 through 1995

	Homeless (n = 220)	Housed (n = 216)	Referent Category	Unadjusted Odds Ratio	*P*
Sociodemographic characteristics, %					
Age 16–20 y	31.4	17.6	. . .	2.32	<.001
Age 21–29 y	40.9	46.3	. . .	1.15	NS
Age 30+ y	27.7	36.1	30+ y	. . .	
Black	22.7	10.2	. . .	2.36	NS
Puerto Rican/Hispanic	36.8	36.1	. . .	1.43	NS
Other	7.7	8.3	. . .	2.11	NS
White	32.7	45.4	White	. . .	
High school graduate	33.6	49.5	No	0.52	<.0005
Factors in respondent's childhood, %					
Ever physically abused	66.5	59.5	No	1.40	NS
Ever sexually abused	43.1	41.7	No	1.05	NS
Ever in foster care	19.6	8.3	No	2.67	<.001
Primary female caretaker ever homeless	14.2	8.3	No	1.82	<.10
Primary female caretaker used drugs	12.3	3.7	No	3.64	<.001
Primary female caretaker supported by work	73.6	83.3	No	0.56	<.01
Primary male caretaker ever homeless	10.3	4.4	No	2.53	<.05
Primary male caretaker used drugs	12.2	8.7	No	0.68	NS
Factors in respondent's adulthood					
Married, %	6.4	5.1	. . .	1.16	NS
Divorced/separated/widowed, %	24.8	30.8	. . .	0.75	NS
Never married, %	68.8	64.0	Never married	. . .	
Hospitalized for mental health problem, %[a]	5.5	0.9	No	6.17	<.01
Frequent alcohol use, %[a]	9.6	1.4	No	7.49	<.001
Frequent cocaine use, %[a]	18.6	3.2	No	6.84	<.0001
Frequent marijuana use, %[a]	18.4	9.3	No	2.20	<.01
Frequent heroin use, %[a]	4.6	0.9	No	5.10	<.05
Ever injected drugs, %	8.3	1.9	No	4.77	<.01
Jailed/in institution, %[b]	6.6	0.96	No	7.28	<.005
No. severe life events, mean (range, 0–11)	1.8 ± .21	1.8 ± .22	. . .	. . .	NS
Financial and emotional support					
No. nonprofessionals in network, mean (range, 0–7)[c]	4.0 ± .24	4.8 ± .25	. . .	. . .	<.0001
Conflict in network, mean score (range, 0–14)[c]	1.6 ± .18	1.3 ± .16	. . .	. . .	<.01
Material resources in network, mean score (range, 0–63)[c]	17.7 ± 1.21	21.7 ± 1.39	. . .	. . .	<.0001
Recent housing history					
No. years lived in Worcester, mean	8.9 ± 1.27	14.2 ± 1.47			<.0001
Lived in Worcester ≤12 mo, %	33.2	11.1	No	3.97	<.0001
Evicted/locked out, %[b]	25.9	16.7	No	1.75	<.05
Primary tenant, %[d]	15.0	77.8	No	0.05	<.0001
Doubled up, %[e]	88.8	49.5	No	8.06	<.0001
Recent income and benefits					
Annual income, $, mean	$7,910 ± 775	$9,988 ± 532	. . .	. . .	<.0001
Ever worked at paid job, %	67.0	73.2	No	0.74	NS
Received AFDC, %[f]	72.3	93.1	No	0.20	<.0001
Received child support, %[f]	9.6	21.9	No	0.37	<.0005
Received housing subsidy, %[f]	10.0	26.9	No	0.30	<.0001
Children					
No. children, mean	2.2 ± .20	2.3 ± .18	. . .	. . .	NS
Average age of children, y, mean	4.5 ± .51	5.8 ± .61	. . .	. . .	<.005
Currently pregnant, %	13.4	5.1	No	2.86	<.001
Gave birth in past year, %	37.9	19.9	No	2.45	<.0001

Note. AFDC = Aid to Families with Dependent Children.
[a]2 years before most recent homeless episode/past 2 years for housed group.
[b]Past year, homeless and housed groups.
[c]Network before first homeless experience/current network for housed group.
[d]Last stable residence for homeless/current residence for housed group.
[e]Past 2 years, homeless and housed groups.
[f]Past year before most recent homeless episode/past year for housed group.

for Windows (version 6.11; SAS Institute Inc, Cary, NC), with the significance criterion for a given variable's entry into the model capped at $P = .20$ (by the Wald test) and that for remaining in the model capped at $P = .05$. For the childhood model, all childhood variables listed in Table 1 that were associated with housing status at the 0.20 level in bivariate analysis were allowed to compete for entry. Indicators for race were forced into the model to control for background differences between the two groups. For the adult model, all variables listed in Table 1 associated with housing status at the 0.20 level in bivariate analysis were allowed to compete for entry after indicators for race, age, and the childhood covariates significantly associated with housing status in the first model were included. All adulthood covariates listed in Table 1 that did not appear in the penultimate adult model were then added back in, one at a time, to ascertain whether the magnitude of one or more of the regression coefficients changed appreciably; nothing was found to suggest the presence of strong confounding by these covariates.

Results

Table 1 lists the demographic, income, housing, and social network characteristics of homeless and housed women that we have previously reported and discussed[13] as well as additional characteristics. Although we documented absolute rates of life events, violent victimization, and mental or substance use disorders, and chronic health conditions that were distressingly high, these factors did not differentiate the two groups and are not reported in Table 1 (see Bassuk et al.[13] for details).

Table 2 presents the final model of childhood predictors of subsequent family homelessness as an adult single parent. Being placed in foster care as a child and having a primary female caretaker who used drugs emerged as independent predictors. Whites were less likely than minorities to become homeless.

Table 3 presents the final model of adult risk factors, with variables that were significant in the childhood model controlled. This model indicates that a number of variables across domains contribute independently to predicting housing status. Risk factors for homelessness include minority status, having lived in Worcester for a year or less, recent eviction from a house or apartment, conflict in one's social network, frequent alcohol or heroin use, recent hospitalization for a mental health problem, and (the perception of) greater resources in one's network.

Protective factors (variables present in greater quantities in or more likely to be characteristic of the housed women) include being a primary tenant, having

TABLE 2—Final Multivariate Logistic Regression Model of Sociodemographic and Childhood Predictors of Family Homelessness in Adulthood

Variable	Referent Category	Adjusted Odds Ratio	95% Confidence Interval	P
Sociodemographic characteristics				
Black	White	3.52	1.92, 6.44	<.0001
Puerto Rican/Hispanic	White	1.65	1.05, 2.60	<.05
Other	White	1.68	.80, 3.54	NS
Factors in mother's childhood				
Ever in foster care	No	2.72	1.47, 5.02	<.005
Primary female caretaker used drugs	No	3.31	1.42, 7.71	<.01

TABLE 3—Final Multivariate Logistic Regression Model of Sociodemographic and Adulthood Predictors of Family Homelessness

Variable	Referent Category	Adjusted Odds Ratio	95% Confidence Interval	P
Sociodemographic characteristics				
Black	White	5.43	2.02, 14.61	<.001
Puerto Rican/Hispanic	White	3.78	1.77, 8.09	<.001
Other	White	4.40	1.25, 15.45	<.05
Age 16–20 y	30+ y	.46	.18, 1.19	NS
Age 21–29 y	30+ y	.62	.28, 1.37	NS
High school graduate	No	.37	.19, .72	<.01
Factors in childhood				
Ever in foster care	No	2.15	.88, 5.26	<.10
Primary female caretaker used drugs	No	3.05	.87, 10.71	<.10
Recent housing history				
Lived in Worcester ≤12 mo	No	4.10	1.83, 9.23	<.001
Evicted/locked out[a]	No	5.52	2.43, 12.54	<.0001
Primary tenant[b]	No	.03	.01, .06	<.0001
Recent income and benefits				
Received AFDC[c]	No	.34	.15, .78	<.05
Receiving housing voucher[c]	No	.26	.09, .74	<.05
Mental health and drug use				
Hospitalized for mental health problem[d]	No	37.96	3.10, 464.2	<.01
Frequent alcohol use[e]	No	23.02	4.83, 109.6	<.0001
Frequent heroin use[e]	No	51.50	5.06, 524.2	<.001
Social supports				
No. nonprofessionals in network[f]	. . .	.54	.39, .76	<.001
Degree of conflict in network[f]	. . .	1.46	1.10, 1.93	<.01
Material resources in network[f]	. . .	1.08	1.01, 1.15	<.05

Note. AFDC = Aid to Families with Dependent Children.
[a]Past year, homeless and housed groups.
[b]Last stable residence for homeless/current residence for housed group.
[c]Past year before most recent homeless episode/past year for housed group.
[d]Past 2 years, homeless and housed groups.
[e]Two years before most recent homeless episode/past 2 years for housed group.
[f]Network before first homeless experience/current network for housed group.

received AFDC and/or a housing subsidy in the prior year, having graduated from high school, and having a larger number of people (nonprofessionals) in one's social network.

Discussion

This epidemiologic study shows that events or conditions that compromise the economic and/or social resources of low-income mothers, and factors that heighten the likelihood of such compromise occurring, are associated with a greater risk of becoming homeless. Conversely, certain factors that buttress these resources may be protective.

Childhood Predictors of Family Homelessness

Researchers have highlighted the importance of adverse childhood experiences in increasing a person's vulnerability to homelessness in studies of both single adults[11,29–34] and families.[2,3,6,7] Although our initial hypotheses were consistent with these findings, we documented that *both* homeless and housed low-income mothers had experienced comparably high rates of early family disruption, trauma, and loss, with two exceptions. Our multivariate model indicates that foster care placement and drug use by the respondent's primary female caretaker are the most salient childhood predictors of subsequent family homelessness in adulthood.

Studies of homeless adults have consistently found that foster care placement during childhood is a risk factor for homelessness.[11,29–33] These studies and our findings suggest that foster care may interfere with the formation of secure attachments and may not provide some children with the skills and supports necessary to establish themselves as self-sufficient adults. However, the modest percentage of homeless women who had been placed in foster care or whose primary female caretaker used drugs indicate that the childhood model is incomplete, since it does not predict homelessness in adulthood for many mothers in the homeless group who did not have these childhood risk factors.

Adult Predictors of Family Homelessness

As Table 3 shows, adulthood variables are especially important for understanding vulnerability to family homelessness. First, factors that increase social or community supports or resources are protective against family homelessness. For example, living in an area for a longer period may lead to increased knowledge of resources and therefore decrease the likelihood of becoming homeless. Also, mothers who completed high school were less likely to become homeless. Research has shown that female high school graduates are more likely than dropouts to be hired into secretarial and skilled blue-collar jobs; these positions are more likely to provide the income and benefits that enable a single parent to be self-supporting.[35] Minority status increases the risk of becoming homeless independently of other explanatory variables in the model. As a result of racial discrimination, minorities may have fewer educational and job opportunities.

Second, factors that increase the likelihood that a mother will have few resources or supports are associated with homelessness. As indicated by prior studies, support networks are critical in the lives of poor women who struggle with substandard housing conditions and many negative life events.[36,37,38] However, research has yielded inconsistent results about the relationship between social supports and homelessness.[2,3,6] This inconsistency may reflect the time frame when the questions were asked (e.g., at the time of requesting shelter vs during a homeless episode), differences in operationalizing this multifaceted construct, and lack of information about the quality of supports. Conflicted relationships may reduce the salutary effect of supports.[39] In our study, homeless women had fewer network members than housed women, and their relationships were more conflicted; both of these differences held up as significant independent predictors of homelessness.

Third, factors that can adversely affect an individual's economic and/or social capital were associated with homelessness. Many studies of adult homeless persons have documented elevated rates of mental health and substance use problems (see Fischer and Breakey[40] for a review). We also found that frequent use of alcohol or heroin was a risk factor. Adjusting for other variables in the model, the estimated relative risks were 23.0 for alcohol use and 51.5 for heroin use. Although use of alcohol or heroin is a very strong predictor, their population attributable risk percentages are less than those for previously mentioned risk factors, owing to the small percentage of women who use these substances frequently. Thus, assuming a causal relationship, eliminating alcohol and heroin use among poor mothers would reduce the risk of homelessness for only a small percentage of families.

Replicating a finding of Weitzman and colleagues,[7] we found that mental health hospitalization within the past 2 years was a strong risk factor for homelessness, even though homeless and housed women in our study were not distinguishable on the basis of lifetime or current prevalence of mental disorders. Like alcohol and heroin use, mental health hospitalization is highly predictive of housing status; yet, as a potential contributor to homelessness, its low prevalence in the at-risk housed population indicates that only a small segment of poor women are vulnerable to homelessness on this basis.

Finally, in contrast to several previous studies,[2,3,7] we found that violent victimization was *not* a risk factor for family homelessness, although it was omnipresent in the lives of homeless and housed low-income mothers. Previous studies have also highlighted pregnancy or the recent birth of a baby as risk factors for homelessness.[41] While pregnancy may play a role in a causal chain leading to homelessness for some women, this variable was not an independent predictor in the adult multivariate model.

Strengths and Limitations of the Study

Our study addresses limitations in previous studies, including deficiencies in instrumentation, small sample sizes, comparison group families who had been homeless in the past, and lack of multivariate analyses. Our study included first-time as well as multiply homeless mothers. There are some differences between these two groups, but analyses that limited the case group to first-time homeless families produced very similar results.

As indicated earlier, we detected some slight differences between women who refused enrollment or dropped out and those who completed the interview. As a consequence of losing some women (owing to the length of the interview), we may have overestimated the association between foster care and housing status as well as that between high school education and housing status. Regardless, the univariate odds ratios in Table 1 are similar to what we would have found had no women dropped out of the study (2.67 vs 2.26 for foster care and .52 versus .54 for high school completion).

While our findings delineate various risk and protective factors for family

homelessness, they do not include all factors that increase vulnerability to homelessness. Our adult model may favor the inclusion of proximal as opposed to distal variables, and it does not elucidate mediating relationships (i.e., causal chains) that constitute complex multistep pathways into family homelessness. A more definitive multivariate model might emerge from a prospective cohort study of families at risk for homelessness; however, we know of no such project that is in progress or being planned.

This study was conducted in one midsize urban community, so its generalizability to cities of different size and characteristics is uncertain. Housing availability, programs assisting low-income families, and racial/ethnic composition vary across communities, and these variations should be considered before generalizing our results. Finally, research at the macro level on factors affecting the supply of and demand for affordable housing is much needed to better understand the root causes of homelessness.

Conclusion

Given recent welfare reform legislation, our findings suggest that families with limited economic resources may be at heightened risk of homelessness if they do not receive economic help during times of need. Government assistance to improve the economic status of low-income families—whether in the form of cash assistance or housing subsidies—may protect families from losing their homes. Moreover, such programs support a family's dignity and are more cost-effective than intervening after the family has become homeless.

These findings may be of use to policymakers and practitioners in identifying families at heightened risk of homelessness and developing preventive interventions. Yet reducing the prevalence of homelessness will also require addressing our nation's shortage of affordable housing for persons with low incomes. Comprehensive strategies that develop housing options and supportive programs that enable women to become economically self-supporting are necessary to eliminate family homelessness and improve the quality of life for those living in poverty. □

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References

1. Bassuk EL, Rubin L, Lauriat A. Characteristics of sheltered homeless families. *Am J Public Health.* 1986;76:1097–1101.
2. Bassuk EL, Rosenberg L. Why does family homelessness occur? A case–control study. *Am J Public Health.* 1988;78:783–788.
3. Wood D, Valdez RB, Hayashi T, Shen A. Homeless and housed families in Los Angeles: a study comparing demographic, economic and family function characteristics. *Am J Public Health.* 1990;80:1049–1052.
4. Goodman L. The prevalence of abuse among homeless and housed poor mothers: a comparison study. *Am J Orthopsychiatry.* 1991;61:489–500.
5. Goodman L. The relationship between social support and family homelessness: a comparison study of homeless and housed mothers. *J Community Psychol.* 1991;19:321–332.
6. Shinn M, Knickman JR, Weitzman BC. Social relationships and vulnerability to becoming homeless among poor families. *Am Psychol.* 1991;46:1180–1187.
7. Weitzman BC, Knickman JR, Shinn M. Predictors of shelter use among low-income families: psychiatric history, substance abuse and victimization. *Am J Public Health.* 1992;82:1547–1550.
8. Buckner JC. Pathways into homelessness: an epidemiologic analysis. In Rog D, ed. *Evaluating Programs for the Homeless.* San Francisco, Calif: Jossey-Bass; 1991.
9. Buckner JC, Bassuk EL, Zima B. Mental health issues affecting homeless women: implications for intervention. *Am J Orthopsychiatry.* 1993;63:385–399.
10. Shinn M. Homelessness: what is a psychologist to do? *Am J Community Psychol.* 1992;20:1–24.
11. Koegel P, Melamid E, Burnam A. Childhood risk factors for homelessness among homeless adults. *Am J Public Health.* 1995;85:1642–1649.
12. Bassuk EL, Browne A, Buckner JC. Families living in poverty. *Sci Am.* 1996;275:60–67.
13. Bassuk EL, Weinreb LF, Buckner JC, Browne A, Salomon A, Bassuk SS. The characteristics and needs of sheltered homeless and low-income housed mothers. *JAMA.* 1996;276:640–646.
14. Susser E, Moore R, Link B. Risk factors for homelessness. *Am J Epidemiol.* 1993;15:546–556.
15. Schlesselman JJ. *Case–Control Studies.* New York, NY: Oxford University Press; 1982.
16. Lilienfeld AM, Lilienfeld DE. *Foundations of Epidemiology.* New York, NY: Oxford University Press; 1980.
17. Rothman KJ. *Modern Epidemiology.* Boston, Mass: Little, Brown & Co Inc; 1986.
18. Stewart B. McKinney Homeless Assistance Act of 1987, 42 USC §11301 et seq (amended 1988).
19. Rog D, McCombs-Thornton K, Gilbert-Mongelli A, Brito MC, Holupka CS. Implementation of the Homeless Families Program, 2: characteristics, strengths and needs of participating families. *Am J Orthopsychiatry.* 1995;65:514–528.
20. *Characteristics.* Worcester, Mass: Worcester Department of Public Welfare; August 1990.
21. *Dynamics of Economic Well-Being: Poverty 1991 to 1993.* Washington, DC: US Bureau of the Census; 1994. Survey of Income and Program Participation. Series P70-45.
22. *1990 Census of Population: Metropolitan Areas.* Washington, DC: US Bureau of the Census; 1990.
23. Barrow S, Hellman F, Lovell A, et al. *Personal History Form.* New York, NY: New York State Psychiatric Institute; 1985.
24. Sarason IG, Johnson JJ, Siegel JM. Assessing the impact of life changes: development of the Life Experiences Survey. *J Consult Clin Psychol.* 1978;46:932–946.
25. Dunst CJ, Trivette CM. *Personal Assessment of Social Support Scale.* Morganton, NC: Western Carolina Center, Family, Infant and Preschool Program; 1988.
26. Dunst CJ, Leet HE. Measuring the adequacy of resources in households with young children. *Child Care Health Dev.* 1987;13:111–125.
27. Straus MA. Measuring intrafamily conflict and violence: the Conflict Tactics (CT) Scales. *J Marriage Fam.* 1979;14:75–88.
28. Spitzer RL, Williams JBW, Gibben M, First MB. *Structured Clinical Interview for DSM-III-R Non-Patient Edition (SCID-NP, Version 1.0).* Washington, DC: American Psychiatric Press; 1990.
29. Susser ES, Struening EL, Conover S. Childhood experiences of homeless men. *Am J Psychiatry.* 1987;144:1599–1601.
30. Susser ES, Lin SP, Conover SA, Struening EL. Childhood antecedents of homelessness in psychiatric patients. *Am J Psychiatry.* 1991;148:1026–1030.
31. Mangine SJ, Royse D, Wiehe VR. Homelessness among adults raised as foster children: a survey of drop-in center users. *Psychol Rep.* 1990;67:739–745.
32. Sossin M, Piliavin I, Westerfelt H. Toward a longitudinal analysis of homelessness. *J Soc Issues.* 1990;46:157–174.
33. Winkelby MA, Rockhill B, Jatulis D, et al. The medical origin of homelessness. *Am J Public Health.* 1992;82:1394–1398.
34. Toro PA, Bellavia CW, Daeschler CV, et al. Distinguishing homelessness from pov-

erty: a comparative study. *J Consult Clin Psychol.* 1995;63:280–289.
35. Spalter-Roth R, Burr B, Hartmann H, Shaw L. *Welfare That Works: The Working Lives of AFDC Recipients.* Washington, DC: Institute for Women's Policy Research; 1995.
36. Belle D. Poverty and women's mental health. *Am Psychol.* 1990;45:385–389.
37. Belle D, ed. *Lives In Stress. Women and Depression.* Beverly Hills, Calif: Sage Publications; 1982.
38. Stack C. *All Our Kin: Strategies for Survival in a Black Community.* New York, NY: Harper & Row; 1974.
39. Rook KS. The negative side of social interaction: impact on psychological well-being. *J Pers Soc Psychol.* 1984;46:1097–1108.
40. Fischer PJ, Breakey WR. The epidemiology of alcohol, drug, and mental disorders among homeless persons. *Am Psychol.* 1990;46:1115–1128.
41. Weitzman B. Pregnancy and childbirth: risk factors for homelessness? *Fam Plann Perspect.* 1989;21:175–178.